VOL 4, No. 3 MARCH 1950

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

CONTENTS

Page

Venereal-disease control in the USA : report of the WHO Syphilis Study Commission 67
New efforts in control of drug addiction 76
Improved hygiene for seafarers 80
Prevalence of plague in recent years 83
Mission to Haiti 87

Reports from WHO Fellows

Tuberculosis control 90

Notes and News

Practice of medicine by foreign physicians 92
Regional organization for Europe 92
Daily radio-broadcast of epidemiological bulletins 92
Roumania decides to withdraw from WHO 92

Views on WHO

International co-operation in malaria control 93
Priorities for international medicine 93
Support of WHO programme 94
Mental health programme 95
Positive achievements of WHO 95
Banner with a strange device 95
Another step to better world health 96

RECENT AND FORTHCOMING MEETINGS

1950

6-30 January	WHO Executive Board : Standing Committee on Administration and Finance, Geneva
9-14 January	WHO Expert Committee on Drugs Liable to Produce Addiction, second session, Geneva
16 January-2 February	WHO Executive Board, fifth session, Geneva
6-11 February	WHO Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel, first session, Geneva
20-26 February	WHO Expert Committee on Nursing, first session, Geneva
27 February-3 March	WHO Expert Committee on Health Statistics : Subcommittee on the Definition of Stillbirth and Abortion, Paris
6-10 March	WHO Expert Committee on Health Statistics : Subcommittee on Cancer Registration, Paris
11-15 April	WHO Expert Committee on Antibiotics, first session, Geneva
11-15 April	WHO Expert Committee on Health Statistics : Subcommittee on Hospital Statistics, Geneva
17 April, tentatively	WHO Expert Group Meeting on Prematurity, Geneva
17-22 April	WHO Expert Committee on Rabies, first session, Geneva
18-22 April, tentatively	WHO Expert Committee on Health Statistics, second session, Geneva
20-29 April	WHO Expert Committee on the Unification of Pharmacopoeias, sixth session, New York
8 May	Third World Health Assembly, Geneva
June	WHO Executive Board, sixth session, Geneva
August	WHO Expert Group Meeting on School Health, Geneva
September	WHO Regional Committee for the Eastern Mediterranean, third session, Ankara
September	WHO Expert Committee on Tuberculosis, fifth session, Geneva
September	WHO Regional Committee for South-East Asia, third session, Colombo

S S

VENEREAL-DISEASE CONTROL IN THE USA

Report of the WHO Syphilis Study Commission

The WHO Syphilis Study Commission has reported to the Expert Committee on Venereal Infections on a study tour made by its members to 13 States and more than 70 public-health, research, and medical centres for syphilis control in the USA.

The Commission consisted of seven members [1] and was set up in accordance with the request made by the Expert Committee on Venereal Infections during its second session that "a temporary study-group, consisting of a limited number of outstanding venereologists from Europe and other regions, be established in 1949 to evaluate the venereal-disease control methods in the United States as to their effectiveness in national and international programmes".[2] A difference of opinion on the treatment of syphilis exists between the supporters of the traditional therapy, still to some extent upheld—particularly in Europe—and the advocates of foreshortened treatment methods, based on penicillin and applied on a large scale in the USA. In recommending the formation of this Commission, during the second session of the Executive Board, Dr Hyde pointed out that the survey could also be of value to the USA as it might serve to suggest improvements in the methods employed there.[3] The report of the Commission, which was extensively discussed by the Expert Committee on Venereal Infections during its third session, held in Washington from 10 to 20 October 1949,[4] is summarized below. [5]

---

[1] The membership of the Commission was as follows :

Dr J. M. Funes, Director, Rapid Treatment Centre ; Chief, Venereal Disease Section, Public Health Service, Guatemala City, Guatemala (*Vice-Chairman*)

Dr E. I. Grin, Director, District Dermato-venereological Dispensary, Ministry of Health, Sarajevo, Yugoslavia

Dr P. C. Joulia, Professeur de Clinique des Maladies cutanées et syphilitiques à la Faculté de Médecine de l'Université de Bordeaux, France

Dr N. Jungalwalla, Deputy Public Health Commissioner, Office of Director-General of Health Services, New Delhi, India

Dr S. M. Laird, Adviser in Venereology, East Anglian Regional Hospital Board, Ipswich, United Kingdom

Dr P. V. Marcussen, Physician in charge, Venereal Disease Clinic, Municipal Hospital, Copenhagen, Denmark (*Chairman*)

Dr T. Putkonen, Chief, State Hospital for Venereal Diseases, Kumpula (Helsinki), Finland

[2] *Off. Rec. World Hlth Org.* **15**, 23

[3] *Chron. World Hlth Org.* 1948, **2**, 251

[4] *Chron. World Hlth Org.* 1950, **4**, 35

[5] The report of the WHO Syphilis Study Commission will be published as *World Health Organization : Technical Report Series*, no. 15

History and Present Organization of Venereal-Disease Control in the USA

Certain outstanding dates mark various stages in the development of venereal-disease control in the USA. In 1876, the President of the American Medical Association suggested that boards of health in every State be given the same powers for venereal-disease control as they already possessed for the control of communicable diseases in general. In 1912, the State of California required its physicians to report cases of venereal disease, and by 1917 nine other States had followed this lead. During the first World War, public interest was stimulated by the fact that venereal diseases were one of the leading causes of rejection of candidates for the armed forces. In 1917, the US Public Health Service urged health officers to require the reporting of venereal diseases by physicians so as to ensure free treatment. Furthermore, the individual States were invited to establish a venereal-disease control division in their health departments. In 1918, Congress approved the setting-up of a Division of Venereal Disease in the US Public Health Service. In 1936, a new law provided for aid to States so that they could establish and maintain preventive and control measures. A wartime programme was instituted in 1940 and further developed in the following years : blood-testing was applied to recruits and rapid-treatment centres were set up throughout the country. Later, treatment with penicillin and other antibiotics was instituted.

The duties of the Division of Venereal Disease of the US Public Health Service include the study of the etiology, prevention, and treatment of venereal diseases, co-operation with State health departments, and prevention of the spread of these diseases by the movement of infected persons from one State to another. In 1948, of a total appropriation of $192,848,100 for health services, $17,399,500 were allocated for venereal-disease control, representing one-half of the total sum spent on venereal-disease control in the USA. The other half is provided from State, local, and private funds. Grants are provided by the Division of Venereal Disease of the US Public Health Service to aid States to set up their own services, to finance research, and for the operation of rapid-treatment centres.

Research

Two types of research are undertaken : scientific and epidemiological. The Division of Venereal Disease of the US Public Health Service has a branch of laboratory and clinical research, and its laboratory, the Venereal Disease Research Laboratory, at Staten Island, New York, is world famous. Other institutes, supported by funds from various sources, also carry out research, which includes all the venereal diseases.

The work deals with the following points, among others : schedules for ambulatory treatment by means of delayed-absorption penicillin

preparations (especially procaine penicillin with 2% of aluminium monostearate) ; penicillin-resistant strains of gonococci ; the effects of fever induced by the Kettering hypertherm method ; treatment with aureomycin and chloromycetin ; the recently developed treponemal antibody technique ;[6] study of the life-cycle of *Treponema pallidum*, using the phase and electron microscopes ; false-positive reactions ; the slide flocculation-test for the diagnosis of syphilis ; preparation of a purified antigen ; trials on the therapeutic value of repository and aqueous penicillin preparations ; search for new antibiotics ; experimental syphilis, especially from the immunological viewpoint, etc.

Other research deals with the epidemiological aspects of control and includes the comparison of various methods for case-finding and contact-tracing, methods which employ either visiting nurses or auxiliary personnel specially trained for this task.

Education

Education, which forms part of all modern programmes for the control of disease, is provided for the three following categories :

(*a*) professional and other groups working in venereal-disease control ;

(*b*) patients ; and

(*c*) the general public.

The postgraduate courses given by the schools of public health, such as those at Harvard University or the Johns Hopkins University, are addressed to the first group, especially to doctors and sometimes to nurses. Furthermore, the US Public Health Service subsidizes chairs of syphilology in certain medical schools. The professional groups are kept informed of scientific research by the *Journal of Venereal Disease Information*, which has a monthly circulation of 15,000 copies. Recently, this journal has been offered free for a period of one year to all senior medical students. Regional seminars, held twice yearly, give the professional groups an opportunity to improve their knowledge. The most recent scientific subjects are dealt with during the annual meetings of the American Venereal Disease Association.

As regards the patient, the aim of education is to instruct him in the nature of his disease and to persuade him of the absolute necessity of continuing the treatment until cured. It would clearly be preferable for this type of instruction to be individual ; however, because of the lack of time and of qualified staff, group instruction is often employed in the hospitals, by means of talks illustrated with films and adapted to the intellectual level of the patients.

---

[6] *Chron. World Hlth Org.* 1950, 4, 42

FIG. 1. WHO SYPHILIS STUDY COMMISSION — I

Right to left (seated round table) :
Dr J. F. Mahoney (Chairman, WHO Expert Committee on Venereal Infections) ; Dr W. Clarke (Executive Director, American Social Hygiene Association) ; Dr N. Jungalwalla ; Dr S. Levitan (Venereal Disease Research Laboratory, US Public Health Service) ; Dr P. V. Marcussen (Chairman) ; Dr P. C. Joulia ; Dr R. C. Arnold (Venereal Disease Research Laboratory, US Public Health Service) ; Dr E. I. Grin ; Dr S. M. Laird ; E. R. Del Vecchio (Serologist, US Public Health Service)

FIG. 2. WHO SYPHILIS STUDY COMMISSION — II

The commission at the Venereal Disease Research Laboratory, Staten Island.
Left to right : Dr R. C. Arnold (Venereal Disease Research Laboratory, US Public Health Service) ; Dr J. M. Funes (Vice-Chairman) ; Dr S. M. Laird ; Dr E. I. Grin ; Dr W. Clarke (Executive Director, American Social Hygiene Association) ; Dr J. F. Mahoney (Chairman, WHO Expert Committee on Venereal Infections) ; Dr P. C. Joulia ; Dr P. V. Marcussen (Chairman) ; E. R. Del Vecchio (Serologist, US Public Health Service)

FIG. 3. WHO SYPHILIS STUDY COMMISSION — III

Examination of follow-up cards of penicillin-treated patients at the Venereal Disease Research Laboratory, Staten Island.
Left to right : Dr R. C. Arnold (Venereal Disease Research Laboratory, US Public Health Service) ; Dr J. F. Mahoney (Chairman, WHO Expert Committee on Venereal Infections) ; Dr. P V. Marcussen (Chairman) ; Dr S. Levitan (Venereal Disease Research Laboratory, US Public Health Service) ; Dr P. C. Joulia ; Dr S. M. Laird

Education of the general public, which is a very important part of the control programme, was started by a voluntary organization, the American Social Hygiene Association, and subsequently expanded by official agencies. At first, the attitude of the public towards the term " venereal diseases " impeded these efforts. However, from 1936 onwards, thanks to the influence of certain public-health officials, the attitude of the public has completely changed, and at present, mass education in this field is more developed in the USA than in any other country. In certain schools, lectures on venereal diseases form part of courses on human biology or domestic economy. Private and public associations make a joint effort. Thus the " Social Hygiene Days " organized throughout the country are utilized for the campaign against venereal disease. A recent propaganda drive in Chicago employed various media of publicity, such as television, radio, the newspapers, posters in street-cars, sky-writing, etc. A survey carried out in one city following such a campaign showed that 31% of the inhabitants were not reached, 54% were slightly better informed, and only 15% were really well-informed. In general, this propaganda gives better results with men than with women, above all in the lower educational groups. The instruction which the men receive in the armed services may serve partially to explain this fact.

Epidemiological Factors in Venereal-Disease Control

Among the factors playing a part in the epidemiology of venereal disease which were studied by the Commission are : the notification of cases, case-finding and the hospitalization of patients, and facilities for diagnosis and treatment.

Morbidity reporting

In order to plan a control programme, it is necessary to know as accurately as possible the total number of cases and their geographical distribution. So as to facilitate the work involved in the collection of data, and their classification and analysis, standard forms have been drawn up in accordance with which the US Public Health Service establishes morbidity reports for the cities. In 1948 the health departments administered 3,000 dispensaries, which reported about 450,000 cases. The notifications of these cases came from clinics, hospitals, various institutions, private physicians, houses of correction, prisons, etc. The recording and analysis of the data are undertaken in the district offices of the venereal-disease-control division (e.g., in New York and Chicago) or in a centre for the mechanical tabulation of statistical data, attached to the State department of health (e.g., in Georgia). Information from local and State levels is passed to the Division of Venereal Disease of the US Public Health Service where it is analysed on a nation-wide basis. It is estimated that

half of the venereal-disease cases are treated by private physicians. The notification of cases by the latter varies from State to State ; it is of the order of 5 to 25% of the total. The Commission felt that this proportion was very low and that an effort should be made to increase it. In small communities, however, identification of patients merely by initials and date of birth might encourage doctors to report cases.

Case-finding and hospitalization

The discovery of all infectious cases is also a very important epidemiological aim. In 1948 the number of cases of syphilis in all stages was about 3,000,000 for the whole population of the continental USA. 338,000 cases were diagnosed, of which only 29.7% had open lesions. 60% of the latter came for medical treatment on their own initiative and 6.8% as a result of contact investigation. Many syphilitics in the primary or secondary stage did not come voluntarily for treatment for various reasons of a psychological nature, or because of lack of money, time, or means of transport.

The search for contacts is a form of case-finding originating from basic principles in epidemiology. Every patient suffering from early syphilis is questioned with the aim of finding individuals constituting a chain of infection, and these persons are requested to undergo medical treatment.

The success of these interrogations depends to a large extent on the tact and competence of the interviewer. Public-health nurses are specially trained for this task, but their insufficient number has made necessary the co-operation of lay investigators fulfilling certain requirements and to whom a training course is given. The number of cases detected by this method steadily increased during 1944 to 1948.

Following the introduction of rapid-treatment methods, the problem of hospitalization has become less acute. Inquiries made in this connexion have shown that 80% of patients follow their treatment regularly ; only 35 out of 952 had to be hospitalized for not complying properly with the conditions of treatment. According to other observations, 96.6% finished a ten-day schedule without difficulty and only 2.1% broke off an eight-day schedule.

Mass blood-testing

Mass blood-testing makes it possible to detect cases of syphilis which have escaped other methods and to estimate the total number of cases in all stages. Thus, for example, in one of the counties of the State of Mississippi, 13,618 persons out of a population of 35,792 were examined. 1,999 cases of syphilis were discovered, including 54 with open lesions. The very high cost of these examinations (about $500 for every case of

infectious syphilis discovered) limits their general application. Consequently, these examinations are at present combined with others, for example, chest x-ray. Serological testing is compulsory in Alabama for certain age-groups, and most States require premarital and prenatal testing.

Diagnosis

Laboratory facilities for diagnosis are free throughout the USA, and they are fully used by hospitals and clinics. Each laboratory makes routine use of one or more tests. Since the introduction of penicillin therapy, the quantitative flocculation tests, and, to a lesser extent, complement-fixation tests, have been extensively employed. Physicians are becoming familiar with the interpretation of the results. They have a growing understanding of the importance of false-positive reactions, a source of erroneous interpretation which is particularly grave when premarital and prenatal tests required by law, or mass blood-testing, are involved. Moreover, the ease of penicillin treatment may induce physicians to arrive at a too hasty diagnosis of syphilis based only on an unconfirmed or doubtful positive reaction. It is important for the medical profession to become increasingly aware of the danger of false interpretation of serological results. Certain laboratories are content to perform only one precipitation test for the diagnosis of syphilis. The Commission felt that two tests, one precipitation and one complement-fixation, should be carried out whenever possible.

Serological tests are periodically evaluated by the Venereal Disease Research Laboratory, whose conclusions are circulated to the laboratories concerned, with the aim of constantly improving these tests. The Commission pointed out the desirability of such systematic comparisons between laboratories, on both a national and an international basis.

Treatment

Treatment for venereal diseases is given in the State and local dispensaries, the rapid-treatment centres for hospitalized patients, and in institutions where separate wings or a certain number of beds are reserved for patients suffering from venereal diseases. Treatment is usually free, or, in some cases, those who are able pay a fee. No case of syphilis goes without treatment because of inability to pay. In certain States, the health departments supply private physicians with antivenereal drugs. The purpose of these services is to promote closer collaboration between the health departments and the private physicians and to increase the facilities for treatment.

Although the latter appear to be adequate on the whole, their distribution is not perfect, for the areas of highest incidence do not always enjoy

the largest number of facilities. In 1948, for example, 127,210 cases of syphilis were reported among the white population and 210,931 among negroes, the respective rates being 98.7 and 1,375.5 per 100,000 inhabitants. As 79% of the negro population—which represents 11% of the total population of the USA—live in the southern States, it would seem that facilities for treatment should be more numerous in these areas with their high syphilis morbidity-rate. Since negroes emigrate from the southern States to the other States on a large scale, risk of the consequent spread of venereal infection is considerable.

The Commission devoted a large section of its report to the results of penicillin therapy in the treatment of early and infantile syphilis as well as in the prevention of prenatal syphilis. These questions have been dealt with in articles published in the *Bulletin of the World Health Organization* [7] and summarized in the *Chronicle*.[8]

Measures against Introduction of Syphilis into the USA

To prevent the introduction of syphilis by immigrants, the laws of the USA provide for the compulsory treatment of all sick persons before their admission. These regulations are not always observed, and many sailors suffering from infectious syphilis enter undiscovered and receive free treatment only later in a dispensary. A number of countries have been authorized to establish their own dispensaries for seamen in US ports. This is to encourage seamen to come for treatment, since they report more readily to doctors speaking their own language. A blood-test is required of immigrants, as well as of workers coming from neighbouring countries. These measures should be of particular interest to countries where the importation of venereal diseases is a grave public-health problem.

Trend of Syphilis as Affected by the US Venereal-Disease-Control Programme

Three questions arise on considering the problem of syphilis in the USA and the results of the campaign against venereal disease :

(1) Is syphilis, in all its stages, decreasing ?

(2) Are early infections with syphilis on the decline ?

(3) What part has the syphilis-control programme played, particularly the widespread use of penicillin, during the past five years ?

The value of the available statistics is limited by several factors, among others by the diversity of the techniques employed for case-finding and

[7] Thomas, E. W. (1949) *Bull. World Hlth Org.* **2**, 233, 249

[8] *Chron. World Hlth Org.* 1949, **3**, 285

morbidity-reporting, the fact that many private physicians do not report cases, and the unknown proportion of cases receiving no treatment. Consequently, it is possible to draw only approximate conclusions ; however, a general picture can be formed.

(1) The proportion of cases observed in the civil population decreased from 3.5 per 1,000 inhabitants in 1941 to 2.3 in 1948. Statistics compiled in two States, Massachusetts and Georgia, lead to some interesting conclusions. In these two States, infection with syphilis is on the decline. The number of cases with respect to the number of inhabitants is much higher in Georgia (3.49 per 1,000 inhabitants, compared with 0.47 in Massachusetts). This difference is mainly due to the fact that 34.7% of the population of Georgia is negro, whereas the corresponding percentage in Massachusetts is only 1.3. However, experience has shown that, for the whole USA, the ratio of syphilis cases among the white to those among the negro population is 1:10. These figures show the importance of the racial factor in the general venereal-disease problem in the USA.

(2) Statistics, as well as the opinion of specialists expressed to members of the Commission at various centres, show that early syphilis is also decreasing.

(3) The trend of early syphilis in the USA during recent years has been almost the same as in other countries, such as Denmark, England and Wales, and Finland—an increase during the war years, reaching a maximum in 1946 (1944 in Denmark), then a decrease. The same phenomenon was observed after the first World War, although Denmark was not a belligerent. This decline in venereal diseases after the increase observed during the war years consequently appears to be natural. It is clear that the decrease in morbidity is encouraged by the facilities for treatment and the control programme at present in force.

In the opinion of the members of the Commission, facilities for treatment and active case-finding measures are more important in the control of syphilis than the use of any one drug in preference to another. However, the existence of a non-toxic drug, such as penicillin, making rapid treatment possible, is obviously a factor of major importance.

In its findings, the Commission stressed that the methods applied in the USA for the control of syphilis could be successfully adapted to other areas. The use of penicillin, particularly in the form of repository preparations, methods for mass blood-testing, standardized laboratory techniques and new ideas applied to the compilation of data and the analysis of statistics, case-finding by means of specially trained lay personnel, the co-operation of private physicians, free diagnosis, consultative and treatment services, and the epidemiological measures employed, may serve as examples to other countries engaged in the campaign against venereal diseases.

Comments by the Executive Board

At its fifth session, held in Geneva from 16 January to 2 February 1950, the WHO Executive Board considered the report of the Syphilis Study Commission, and recommended that it should be given the widest possible distribution. The Board expressed considerable interest in this type of WHO activity, which aims at the study of special international health problems, and was in favour of the establishment of further study commissions as a means of stimulating the exchange of information between national health-administrations and WHO.

NEW EFFORTS IN CONTROL OF DRUG ADDICTION

A new convention dealing with the control of addiction-producing drugs has now been prepared by the Division of Narcotic Drugs of the United Nations. This " Unified Convention " is intended to replace the various existing diplomatic instruments: the 1925 and 1931 Conventions —amended in 1946—and the 1948 Protocol, which came into force on 1 December 1949. The Commission on Narcotic Drugs of the Economic and Social Council requested WHO to provide it with definitions for some basic terms to be included in the new convention. The establishment of these definitions is one of the questions which the Expert Committee on Drugs Liable to Produce Addiction [1] discussed at its second session, held in Geneva from 9 to 14 January 1950.[2]

---

[1] Formerly the Expert Committee on Habit-forming Drugs. Following the recommendation of the committee itself, the Executive Board, at its fifth session, decided to change the denomination of the Expert Committee on Habit-forming Drugs to " Expert Committee on Drugs Liable to Produce Addiction "; see also under " Habit-forming drugs ", page 77.

[2] The following took part in this session :

Members :

J. Bouquet, Docteur en pharmacie, ex-Pharmacien des Hôpitaux de Tunis et ex-Inspecteur des Pharmacies de Tunisie, Tunis, Tunisia
Dr N. B. Eddy, Medical Officer, National Institutes of Health (US Public Health Service), Bethesda, Md., USA (*Chairman*)
J. R. Nicholls, D.Sc., Deputy Government Chemist, Government Laboratory, London, United Kingdom

Consultants :

Dr R. E. Carratalá, Professor of Toxicology, La Plata National University, Buenos Aires, Argentina
Sir Ram N. Chopra, Professor of Pharmacology; Director, Drug Research Laboratory, Srinagar, Kashmir
Dr G. Joachimoglu, Professor of Pharmacology; Chairman, Superior Health Council, Ministry of Hygiene Athens, Greece

Representatives of the United Nations :

L. F. Atzenwiler, Assistant Secretary, Permanent Central Opium Board and Drugs Supervisory Body, Geneva
B. Celinski, Division of Narcotic Drugs, Lake Success, N.Y.
J. Dittert, Statistician, Permanent Central Opium Board and Drugs Supervisory Body, Geneva

Secretary :

Dr P. O. Wolff, Chief, Addiction-producing Drugs Section, WHO

Dr H. P. Chu, Professor of Pharmacology, National Medical College, Shanghai, China, was unable to attend.

Basic Definitions

The committee suggested the following three definitions:

Drug addiction. " Drug addiction is a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:

(1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;

(2) a tendency to increase the dose;

(3) a psychic (psychological) and sometimes a physical dependence on the effects of the drug."

Addiction-producing drugs. " An addiction-producing drug is one which produces addiction as defined." The committee added that, according to information at present available, any substance which will sustain an established addiction must be considered as also capable of producing an addiction.

Habit-forming drugs. " A habit-forming drug is one which is or may be taken repeatedly without the production of all of the characteristics outlined in the definition of addiction and which is not generally considered to be detrimental to the individual and to society."

The committee was of the opinion that the expression " habit-forming " in the sense of " addiction-producing " should be eliminated from all texts relating to drug addiction. It was for this reason that it proposed that its own denomination should be changed.

Other Requests from the Commission on Narcotic Drugs

Fundamental structure of an addiction-producing drug. The committee had been asked to give its opinion on the fundamental structure of addiction-producing drugs. This raises the question as to whether addiction is related to a special chemical structure. The committee felt that this question could not yet be answered definitely and that, in the present state of our knowledge, it is impossible to say what part of the molecule of a drug is responsible for its addiction properties.

Medical research on drug addiction. The Commission on Narcotic Drugs wished to know the present position as regards medical research on drug addiction. Exchanges of view within the committee revealed that investigations on this question were still at an initial stage. In fact, the only systematic medical researches of which the members of the committee were aware were those being carried out under the auspices of the US Public Health Service in the Research Division of the hospital

FIG. 4. EXPERT COMMITTEE ON DRUGS LIABLE TO PRODUCE ADDICTION, SECOND SESSION

Left to right (seated round table) : Dr R. E. Carratalá ; Dr G. Joachimoglu ; Sir Ram N. Chopra ; J. R. Nicholls ; Dr N. B. Eddy (Chairman) ; B. Celinski (United Nations) ; Dr P. O. Wolff (WHO) ; P. Blanc (WHO) ; J. Bouquet

at Lexington, Kentucky, and those of certain groups of investigators in South America. Consequently, the committee recommended that governments be urged to undertake or amplify medical research on this question.

Requests Submitted by Governments

The committee considered the request submitted by certain governments.

Ipecopan. A request was submitted by the Swiss Government that " ipecopan ", a mixture of emetine and cephaeline hydrobromides with the total alkaloids of opium (in the form of hydrochlorides), should be exempted from strict control under the 1925 Convention. The committee was unable to accept this proposal, inasmuch as ipecopan contains a morphine salt in an amount equivalent to 37% of anhydrous morphine, so that it would be possible to recover the morphine content by simple means.

Morpholylethylmorphine. The French Government requested that a new product, morpholylethylmorphine, should be included in Group II of the first Article of the 1931 Convention, i.e., in the codeine group, which is subject to less severe provisions than the other ethers of morphine. This request was based on an examination of the pharmacological properties of morpholylethylmorphine which, while being three times less toxic than codeine, is as active as the latter and superior to it in certain other respects. The committee considered that there were not sufficient data available for the addiction-producing properties of morpholylethyl-

morphine to be estimated, and that this compound was probably convertible to morphine. Furthermore, because of its chemical constitution, it should be included among the ethers of morphine other than methylmorphine (codeine) and ethylmorphine, and be subject to the restrictions applying to this group.

Other Questions

Chronic barbiturate intoxication. In many countries, the abuse of barbiturates is creating more or less acute problems. In the USA, production of these substances has considerably increased in the course of the last few years; in 1948, it exceeded, by an appreciable amount, the quantity necessary for medical use, reaching a level equivalent to about 24 therapeutic doses per head of population. An increasing number of morphine addicts are taking to barbiturates as well. The committee took note of certain experiments which have been carried out in the USA with the object of determining the effects of chronic barbiturate intoxication. Prolonged administration—for 92 to 144 days—gave rise to symptoms of intoxication similar to those of alcoholism and induced marked tolerance. Sudden withdrawal produced a distinct abstinence-syndrome, characterized by the disappearance of the signs of intoxication, by various physiological effects, and by a psychosis resembling alcoholic delirium tremens. From these experiments it may be concluded that the barbiturates are liable to produce addiction.

2-(1'-naphthylmethyl)-imidazoline. Addiction to 2-(1'-naphthylmethyl)-imidazoline, the hydrochloride of which is known as " privine " or " diazolin ", is spreading in Argentina. The committee felt that this problem was similar to that of the abuse of amphetamine which was raised at the previous session, and that, for the time being, there was no need to recommend international measures.

Other substances. The committee took note of new information concerning various addiction-producing drugs, such as certain compounds prepared during research on the synthesis of morphine. It repeated the recommendations formulated at its first session on the dangers of using " keto-bemidone " and diacetylmorphine (heroin).[3]

The report on the second session of the Expert Committee on Drugs Liable to Produce Addiction will be published shortly as *World Health Organization : Technical Report Series*, no. 21.

---

[3] *Off. Rec. World Hlth Org.* 19, 30, 31; see also *Chron. World Hlth Org.* 1949, 3, 28, 29

IMPROVED HYGIENE FOR SEAFARERS

The hygiene of seafarers was the subject of two important meetings of experts which were held recently. From 10 to 20 October 1949, a working party of the Expert Committee on Venereal Infections [1] met in Washington to study the special problem of control of venereal diseases among seamen. The Joint ILO/WHO Committee on the Hygiene of Seafarers, which held its first session in Geneva from 12 to 14 December,[2] discussed certain of the problems concerning the health of seafarers, such as tuberculosis, venereal diseases, the organization of medical examinations, problems of hospitalization, etc.

It is, of course, difficult to guarantee to seafarers medical service and social security such as other sections of the population enjoy. Nevertheless, the International Labour Organization (ILO) and WHO are making efforts to improve the present situation. Conventions dealing with the medical examination of seafarers, food and catering for crews, and crew accommodations on board ship have already been drawn up by ILO. There are still many problems to be solved, however, before the standards of hygiene of seafarers can be further raised.

Tuberculosis

The committee was of the opinion that, while a complete medical examination of all seafarers was desirable at the time of first appoint-

---

[1] The following were present at the meetings of this working party :

Members :

Dr W. E. Coutts, Professor of Venereology ; Chief, Department of Social Hygiene, Public Health Administration, Santiago, Chile

Dr E. H. Hermans, Medical Director, Anti-Venereal Disease Association, Rotterdam, Netherlands

Dr G. L. M. McElligott, Director, Venereal Disease Department, St. Mary's Hospital ; Adviser in Venereal Diseases, Ministry of Health, London, United Kingdom (*Chairman*)

Consultants :

Dr N. Jungalwalla, Deputy Public Health Commissioner, Office of Director-General of Health Services, New Delhi, India

Dr T. Putkonen, Chief, State Hospital for Venereal Diseases, Kumpula (Helsinki), Finland

[2] The following were present at this meeting :

Members :

ILO :

O. Bécu, Président de l'Union des Ouvriers du Transport, Antwerp, Belgium

Captain O. I. Loennechen, Vice-President, Norwegian Shipowners' Association, Tonsberg, Norway

R. Snedden, General Manager, The Shipping Federation, London, United Kingdom

T. Yates, General Secretary, National Union of Seamen, London, United Kingdom

Adviser :

Dr E. L. Caldwell-Smith, Chief Medical Officer, The Shipping Federation, London, United Kingdom

WHO :

Dr T. B. H. Anderson, Medical Director, US Public Health Service ; Medical Officer in Charge, US Marine Hospital, Staten Island, N.Y., USA

Dr K. Evang, Director-General of Public Health, Oslo, Norway (*Chairman*)

Dr H. N. C. V. Kelaart, Divisional Medical Superintendent of Health, Department of Medical and Sanitary Services, Colombo, Ceylon

Dr H. D. keid, Chief, Division of Quarantine, Immigration, Medical, and Sick Mariners' Services, Ministry of National Health and Welfare, Ottawa, Canada

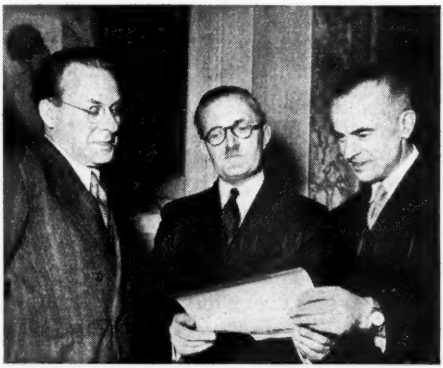
Secretaries :

Dr G. W. Miller, Assistant to the Director, Division of the Organization of Public Health Services, WHO

J. L. Mowat, Chief, Maritime Section, ILO

ment and at regular intervals afterwards, all countries did not have facilities for carrying out such examinations. It was therefore decided that this matter should be further examined with a view to evolving a plan later for a more general physical examination which could be universally applied. The committee also discussed the question of rehabilitation for seamen who had suffered from tuberculosis. It was generally agreed that many sufferers might not afterwards be fit for service at sea, although they might be perfectly fit for other less strenuous occupations. The committee noted that vocational guidance and training were necessary to ensure that the ex-seamen should be fitted for other employment.

FIG. 5. JOINT ILO/WHO COMMITTEE ON THE HYGIENE OF SEAFARERS



Left to right : O. Bécu ; R. Snedden ; Dr K. Evang (Chairman)

Venereal Diseases

The Brussels Agreement of 1924, " respecting facilities to be accorded to merchant seamen for the treatment of venereal diseases ", should be amended, owing to its limited scope. It makes no provision for the statistical and epidemiological evaluation of the problem of venereal diseases among seafarers ; in addition, the scope of these sanitary regulations should be enlarged to include river boatmen. The question of amending the Brussels Agreement is at present under review.[3] However, the draft text of the new regulations cannot be submitted before the Expert Committee on International Epidemiology and Quarantine has completed the text of the regulations concerning pestilential diseases.[4] Until the new regulations are established, WHO should concentrate on obtaining wider adherence to the Brussels Agreement, seeing that it has been ratified by only 21 States.

A plan for revising the individual treatment booklet, which was introduced under the Brussels Agreement, was proposed by the Washington working party. This modified booklet should be sent by WHO to the various national health-authorities, together with a revised edition of the international list of treatment centres for venereal diseases.

[3] See *Off. Rec. World Hlth Org.* **8**, 65 ; **15**, 28.

[4] *Chron. World Hlth Org.* 1949, **3**, 1 ; 1950, **4**, 46

Treatment

The use of certain repository penicillin preparations would seem to be the best means of rendering syphilitic chancres rapidly non-infectious and of arresting gonorrhoea. Further research along these lines should be continued, for this method would enable seamen to resume duty soon after intensive treatment. At the present time, treatment with repository penicillin is carried out only in certain countries ; and, before WHO makes any definite recommendations in this matter, it would be useful to study the methods of treatment employed in various centres.

The working-party experts emphasized that the use of penicillin on board vessels, without any kind of medical control, could not be allowed. This practice leads to considerable loss of epidemiological information and to unfortunate gaps both in the diagnosis and in the post-treatment observation of patients.

Port and river projects

The co-operative effort in the control of venereal diseases undertaken by the health authorities of the States bordering on the Rhine [5] was stressed by the Washington working party. This anti-venereal-disease activity has aroused such interest that the States on the shores of the Baltic have requested WHO's assistance in setting up in their area a commission based on the same principles.

Dr E. H. Hermans, Medical Director of the Anti-Venereal-Disease Association, Rotterdam, submitted a remarkable report at Washington concerning the guiding principles which must govern venereal-disease control in sea- and river-ports. The report deals with the setting-up and running of treatment centres, laboratory methods, treatment on board vessels, welfare work, anti-venereal-disease instruction and propaganda, the treatment booklet, international exchange of information, international co-operation within the various river areas, state insurance, etc.

Further venereal-disease-control demonstrations might well be carried out in ports of the Eastern Mediterranean or of South-East Asia.

Regulations

The Washington working party made special recommendations regarding the free treatment of venereal diseases and the duty incumbent upon doctors and medical institutions of notifying the various national health-authorities, for statistical purposes, of infectious cases of venereal disease ; such notifications should also include a reference to the source of the infection.

In the opinion of the joint committee, serological tests should be made compulsory for seamen before they are admitted to the profession.

---

[5] *Chron. World Hlth Org.* 1949, 3, 117

Organization of Medical Services

The results of the preliminary medical examination and of the subsequent periodical examinations should be entered on each man's individual medical record, possession of which should be compulsory in order to obtain employment. The joint committee, however, reserved for further consideration, the confidential nature of the information concerning the state of health of sailors.

Hospital Facilities

The committee considered the various problems associated with the treatment of the seafarer in foreign ports. This discussion included such questions as rapid transportation from ship to hospital, suitable hospital food, and the minimum requirements for medical chests on ships.

Many countries have an inadequate hospital system with varying standards of medical care. The committee proposed that information should be obtained on hospital facilities and conditions at various ports, so that certain hospitals could be recommended as being entirely reliable for the treatment of seafarers.

PREVALENCE OF PLAGUE IN RECENT YEARS

The present decrease in the incidence of pandemic plague, as revealed by statistics, does not justify the assumption that the disease has lost its power to spread. In fact, in certain countries it has been found that the relaxation of control measures during the war and the postwar period has resulted in extensive outbreaks.

It is true that a large number of areas formerly seriously infested, for example, Europe, are today free from the disease. In other areas, such as Egypt, Libya, and Syria, which have been particularly subject to pandemics for centuries, only sporadic cases now occur. In regions where plague is transmitted by domestic rodents, it is now possible to protect human communities from this scourge by the general application of measures for disinsection and deratting. Thus in South America it has been proved that, by employing DDT and 1080 (sodium fluoracetate), it is possible to wipe out plague in the towns and villages.[1] However, while foci of endemic plague still persist, the tenuous barrier represented by quarantine measures will not suffice to ensure absolute protection against the risk of infection. Wild-rodent plague, in particular, which is a potential source of

[1] *Chron. World Hlth Org.* 1948, **2**, 254

infection for man, continues to spread in South Africa and the Americas and remains a serious menace.

The above observations were made by Dr P. M. Kaul, Division of Epidemiology, World Health Organization, in an article entitled " Prevalence of plague in the world in recent years ".[2] From this detailed account, which includes maps, graphs, and tables, only a few facts relating to the epidemiology, etiology, and therapeutics of plague will be given.

On the basis of the available data, it may be stated that bubonic plague now occurs in an active state only in the following areas :

Africa :	Azores, Belgian Congo, Kenya, Madagascar, Senegal, South Africa, South-West Morocco, Tanganyika
Asia :	Burma, China, India, Indochina, Java, Thailand
South America:	Argentina, Bolivia, Brazil, Peru

Africa

It is believed that the history of plague in Egypt is very old; since 1899 cases have been reported nearly every year. From 1907 onwards, the province of Assyut became an important focus of infection: 90% of the cases reported in the country from 1938 to 1940 occurred in this province. During the 1939 and 1940 epidemics, it was noticed that the buildings where the first cases of plague occurred had pigeon-houses on their roofs. Such buildings are numerous, since the inhabitants utilize the pigeon excreta for manure. The connexion between pigeon-houses and plague may be explained by the fact that rats frequent such places in search of eggs and young birds, and this increases the danger of the transmission of the disease.

Morocco was free from plague from 1936 to 1939. The disease reappeared in the south of the country in 1940; there were two epidemics in the Casablanca area, in 1942 and in 1945. Since 1946, no cases of plague have been reported in Morocco. In Algeria, the disease was introduced in 1899, but has never become widespread; sporadic cases have been observed, with slight epidemic outbreaks. The position in Tunisia has been similar.

In Kenya, which is an important East African plague centre, there has been a decrease during recent years. The number of cases fell from 1,101 in 1925 to 29 in 1948, with a few epidemic outbreaks in 1941 and 1942. Uganda, too, has always been considered as a focus of plague; from 1939 to 1942, about 300 cases were reported there each year. However, a sudden decrease took place in 1943, there being only 19 cases in that year. Plague control undertaken during this period comprised the preventive inoculation of persons especially exposed to the risk of infection, the quarantine of

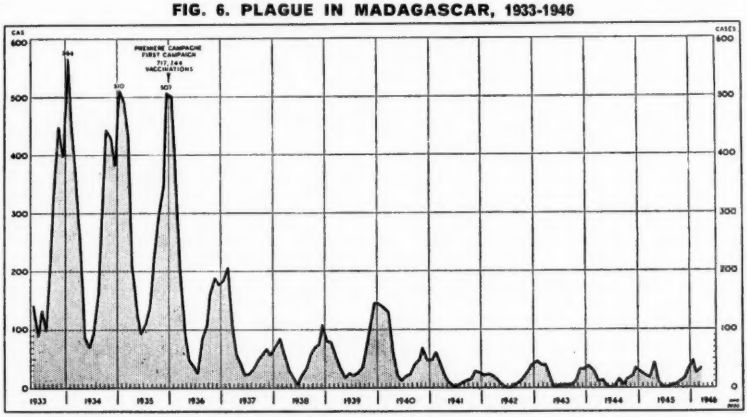
[2] *Epidem. vital Stat. Rep.* 1949, 2, 143

plague cases, and, above all, deratting and disinsection. Wild-rodent plague is unknown in Uganda. Since 1928, the annual number of cases in the Belgian Congo has not exceeded 73 and since then has decreased still further.

In southern Africa, the permanent reservoir of plague is constituted by gerbils, which transmit infection to other rodents, particularly to multimammate mice which, in turn, transmit it to man. An epizootic is considered responsible for the rapid spread of an epidemic in Ngamiland in October 1944. Plague was introduced into the Union of South Africa at the beginning of the twentieth century and spread from the ports into the rural areas. The cases of plague usually occurred at times when mortality among domestic rodents was high, following an epizootic among the gerbils. Rodent plague is now endemic throughout the greater part of the Union and is spreading into adjoining territories. The incidence of human plague, which attained a maximum in 1935 and 1936 (586 cases in these two years), is now declining.

In Madagascar, from 1899 to 1907, plague occurred in small, sporadic outbreaks confined to the ports. Since 1921, the disease has become endemic along the high plateau. After having reached a maximum in 1933, with 3,887 cases, infection has now decreased. The annual number of cases, from 1943 to 1948, varied between 184 and 278. The disease is characterized in the island by a high death-rate—96% in 1933 and 78.5% in 1947. Preventive inoculation with Girard's EV living plague vaccine is considered very effective. As shown by Legall, the average morbidity-rate per 10,000 inhabitants was 25.3 per year before the introduction of inoculation, i.e., in the period from 1930 to 1934; with inoculation, the annual average rate decreased to 4.6 for the years 1937 to 1941 (see fig. 6).

FIG. 6. PLAGUE IN MADAGASCAR, 1933-1946



Number of cases reported per month

America

Plague first appeared in the United States in 1900, in the Chinese quarter of San Francisco. Since then, and until quite recently, a number of plague cases have occurred almost every year in California. In all, 503 cases were reported in the USA between 1900 and 1944. Since 1924 there have been no epidemics of human plague, either of urban or of murine origin, in the country. The sporadic cases reported were accidentally infected during epizootics among wild rodents. Research carried out in wild-rodent plague, in territories representing 40% of the area of the continent, has shown that the infection is widely distributed in 15 Western States. In 1945, it spread towards the east, reaching Kansas and the adjoining area of Nebraska. This eastward advance is a menace, since wild-rodent plague may infect the rodents of the great plains, the Mississippi valley, and the eastern United States. The disease has been found in 40 species of rodents (ground squirrels, rats, marmots, meadow-mice, cotton-tail rabbits, prairie dogs, etc.). Infected fleas were taken from various rodents, especially chipmunks, weasels, and badgers.

Brazil was one of the first South American countries to be affected by plague. Since 1899, the disease has spread from the ports of Santos and Rio de Janeiro over a large section of the country, where it is now endemic. A total of 757 cases was recorded during the years 1946, 1947, and 1948. The death-rate, which is relatively low, continues to decrease further following the introduction of sulfonamide therapy; it fell from 33% in 1934 to 13% in 1948. Recently, avirulent live vaccine has been used instead of the Haffkine type of vaccine.

Peru is the South American country which has suffered most from plague. There were nearly 20,000 cases between 1903 and 1929. However, there has been a marked decrease since 1930 (2,870 cases between 1930 and 1944, 464 cases between 1945 and 1948).

Asia

The period of maximum spread of plague in India, where it was imported from China in 1896, was during the years 1901 to 1907. Since then, the incidence has declined. The number of deaths, which reached six million for the period 1900 to 1909, fell to less than 500,000 for the period 1931 to 1939. The position became worse again in 1943 because of the war, but in 1948 the mortality was slightly below that in 1942, which had been a minimum. In a report summarized in a preceding number of the *Chronicle*,[3] Sharif described the endemic areas in India, their climatic conditions, and the way in which plague is spread, as well as pointing out the part played by the domestic rat in transmitting the disease.

---

[3] *Chron. World Hlth Org.* 1949, 3, 270

In Java, plague was first reported in 1910 and spread rapidly, soon becoming an epidemic and advancing from east to west as the antiplague campaign destroyed the rats in the houses. Although it decreased between 1915 and 1918, the incidence began to increase in 1919 and epidemics have occurred every year since then, the most serious being in 1933 and 1934. The incidence of the disease then declined again, so that in 1940 only 312 cases were reported. This decrease would probably have been more pronounced if the war had not intervened. The incomplete information obtained during recent years does not make it possible to follow the general trend of the disease. However, it is known that, according to preliminary data, 3,422 cases and 3,365 deaths occurred during the first 42 weeks of 1948, which indicates a very considerable plague infection.

In China, notification of communicable diseases is not yet practised throughout the country. The reporting of cases of plague, although more thoroughly carried out than that for other diseases, is limited to some ten provinces. Incidence was very high during the period 1940 to 1947, reaching some 11,000 cases with 6,000 deaths in 1946, and then falling to about 3,000 cases in 1948. The construction of the new Burma road resulted in 1939 in the infection of Yunnan, from the adjacent endemic focus in Burma.

The last part of Dr Kaul's article deals with plague in seaports and airports. In the opinion of the author, all the large ports might soon have been free from plague if the international situation had remained normal. However, because of the war, plague reappeared in several Asiatic and African ports. Following the infection of the Suez Canal and North African ports, the disease made its appearance in a few European ports in the Mediterranean ; since 1946, however, no cases have been reported there.

MISSION TO HAITI

A WHO expert in tropical hygiene, Dr A. Kundig, was one of a group of United Nations experts sent to the Republic of Haiti, at the request of its government, to study the possibilities of economic and social development. This request was made in accordance with the resolution, passed by the Economic and Social Council on 28 March 1947, to aid governments seeking technical advice: a team of experts would study specific problems on the spot and would recommend appropriate solutions for them.

Thus the mission to Haiti was entrusted, first and foremost, with the study of the "problems of and the conditions affecting the economic development of Haiti primarily in the fields of agriculture, industry and related activities, having regard to the inter-related economic and social

problems bearing, in particular, on the improvement of health and education". In the light of this study, the mission was "to formulate proposals as to practicable measures" and "to appraise the needs . . . implied by the measures proposed".[1]

The group of experts was composed of representatives of the United Nations, the International Monetary Fund, FAO, UNESCO, and WHO.

An undertaking of this nature constitutes a concrete example of international co-operation in technical assistance, and, in the words of Mr Trygve Lie, Secretary-General of the United Nations: "This Mission is . . . a precursor of the ampler efforts which . . . the international organizations concerned will be enabled to display in realization of the bold programme of technical assistance to underdeveloped countries . . .". [2]

In the introduction to the report submitted by the mission, the experts set forth the essential facts of the present situation in Haiti and make recommendations of a general nature.

The report itself consists of two parts. In the first, demographic, educational, and health problems affecting the economic position of Haiti are examined. In the second, transport, production, commercial, and financial problems are studied. Recommendations are made in connexion with each particular problem.

The population of Haiti, which was estimated at 3,000,000 in 1948, is essentially agricultural. There is practically no medical care for the rural inhabitants, who represent about four-fifths of the total population. In fact, of 292 physicians practising at the end of 1948, there were only 26 to look after the rural population of more than 2,500,000. There is no doubt that this situation constitutes the principal obstacle to the economic development of Haiti. The urban population is better provided for, as regards both hospital facilities and medical personnel.

The public-health organization consists of a central department and provincial administrators. The central department, which has a director-general at its head, comprises 6 technical and administrative divisions dealing with the following problems: epidemiology and prevention of epidemics, malaria, vital statistics, quarantine, hospitals, and clinics and dispensaries in the rural areas. The Director-General is also responsible for the 11 provincial districts, where the local administrator also acts as physician-in-charge of the district hospital. In general, the physicians-in-charge of these hospitals are surgeons and have no training in rural health matters. Moreover, their work is hampered by lack of transport and, because of inadequate remuneration, they are unable to devote themselves entirely to their official duties. A number of the 105 rural clinics

---

[1] United Nations (1949) *Mission to Haiti. Report of the United Nations Mission of Technical Assistance to the Republic of Haiti*, Lake Success, N.Y. (1949.II.B.2.) p. xiii

[2] United Nations (1949) *Mission to Haiti* . . ., Lake Success, N.Y. p. iii.

and dispensaries are closed because of financial and other difficulties; furthermore, the staff in these establishments is unqualified.

Rural housing is unhealthy; the people make constant use of surface water; latrines and other sanitary installations are lacking. Demographic and nosologic statistics are distinctly inadequate. Infectious diseases are believed to cause 40% of deaths, of which 46% are attributed to tuberculosis. However, these statistics are based only on incomplete data. The prevalent diseases are reported to be yaws, malaria, tuberculosis, and, to a certain extent, ankylostomiasis. At least 85% of the inhabitants of certain rural areas are reported to suffer from yaws.

Malaria is probably very widespread, but statistical data, which are indispensable for suggesting appropriate measures, are lacking. The malaria vectors are reported to be *Anopheles albimanus*, *A. grabhamii*, *A. vestitipennis*, and *A. crucians*. Drainage projects were carried out between 1942 and 1946 under the auspices of the Rockefeller Foundation, but lack of maintenance has practically obliterated these efforts.

One of the factors causing the spread of tuberculosis is overcrowding in hovels, particularly in the slum quarters of Port-au-Prince. The incidence of this disease in rural areas is unknown. There is only one sanatorium in Haiti, that at Port-au-Prince. The hospital services for contagious cases, even at the General Hospital of Port-au-Prince, are inadequate and poorly organized.

The mission formulated recommendations aiming, above all, at the establishment of a satisfactory public-health organization in the rural areas. This would require the health administrators of the rural districts to take technical training in public health, and to devote the whole of their time to the rural health services. It would be essential, therefore, to remunerate them adequately and to ensure for them the necessary means of transport.

Before tackling the practical problems of malaria, tuberculosis, and ankylostomiasis control, it is advisable to survey thoroughly the incidence of these diseases in rural areas. It would also be very important to maintain the sanitary improvements already achieved and the installations which have already been constructed for malaria control.

The mission also recommended either that the project for the construction of a new hospital at Bel Air (Port-au-Prince) be reconsidered or that a more economical solution, such as enlarging the General Hospital, be adopted.

Yaws was made the object of special recommendations, since the disablement caused by this disease seriously impairs capacity for work. The mission suggested that the campaign against yaws be organized on a nation-wide scale and that efforts be concentrated over a period of two to three years. For this purpose it would be necessary to provide the rural clinics and dispensaries with the drugs necessary for the treatment of

yaws. Penicillin in oil and beeswax is the drug of choice (2 injections administered at an interval of from 10 to 12 hours). The campaign could be successfully carried out by 12 physicians, each assisted by 5 medical aides, and their practice would cover the rural clinics scattered throughout the country. Each physician would direct 5 rural clinics.

The cost of such a campaign would be very high, but its influence on the economic development of the country would be considerable.

Reports from WHO Fellows

Many of the letters and reports received from WHO Fellows have been of such interest that they deserve to be read by a wider public. They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves. Selections from these reports have therefore been published from time to time, but it must be emphasized that the opinions expressed are those of the Fellows.

Tuberculosis Control

Dr M. C. Verghese, Chief Tuberculosis Officer, Trichur, State of Travancore and Cochin (India), was awarded a WHO fellowship in order to study methods for the prevention and treatment of tuberculosis in Western Europe and North America. Between February and October 1949, he travelled in Great Britain, Denmark, Sweden, Norway, the USA, Canada, France, Switzerland and Italy, visiting public-health administrations, schools, research centres, and hospitals and sanatoria.

Dr Verghese noted that tuberculosis control was one of the major preoccupations of the health authorities of all the countries he visited ; indeed, as a result of the second World War, tuberculosis morbidity and mortality have increased almost everywhere.

In all these countries voluntary organizations are co-operating with governments in tuberculosis control, their efforts being concentrated on prevention aspects : propaganda, education, and compilation and distribution of information, etc. In Italy, the National Antituberculosis Federation is also responsible for the medical and scientific aspects of the campaign against the disease.

The development of these voluntary bodies is an indication of the growing number of persons interested in the antituberculosis programmes. Thus, one of the finest children's sanatoria in Denmark, built in 1939, is financed solely by the sale of special tuberculosis stamps every Christmas. Denmark is, moreover, the country with the world's lowest tuberculosis mortality rate. Progress in antituberculosis work dates from 1901 with the formation of the National Society for the Prevention of Tuberculosis ; since 1905 the State has supported campaigns organized by this voluntary body through an Act providing State subsidies for tuberculosis hospitals.

It is of vital importance, first for studying and then for checking the ravages of tuberculosis, to be in possession of as accurate statistical data as possible. In all the countries visited by Dr Verghese he found that registration and statistical services exist which enable close attention to be given to tuberculosis morbidity and mortality figures, as well as to the results of preventive measures and of treatment. In Denmark, death certificates from physicians are sent, before they are finally recorded, to the Central Tuberculosis Dispensary for verification of the diagnosis. In Rome, the Istituto Carlo Forlanini has made a series of comparative statistical surveys of the tuberculosis problem in Italy and in various other countries.

Dr Verghese emphasized that in all the countries he visited tuberculosis was a compulsorily notifiable disease, and that steps were taken everywhere to isolate cases and give them hospital treatment. Several countries have undertaken mass-radiography campaigns among whole sections of their populations. In certain parts of Great Britain, notably Edinburgh, apprentices undergo clinical and x-ray examinations ; similar examinations are made of pregnant women attending antenatal clinics.

In Western Europe and in the USA, the number of hospital beds available varies from one to three per death due to tuberculosis ; but, in view of the growing number of cases which mass-radiography daily reveals, there is a definite shortage of beds. In certain States in the USA it is compulsory by law for the families of persons suffering from tuberculosis either to hospitalize the patients or to take in their own homes a series of specific precautions designed to prevent infection. In England, the number of hospital beds for tuberculosis cases is adequate, but there is a lack of trained nursing staff. Hence home medical treatment is practised.

Dr Verghese observed that medical authorities were also concerned with the control of non-pulmonary tuberculosis, a great many cases of which are due to infection with the bovine type of tubercle bacillus. The recent decline in the morbidity rate is certainly the result of increased use of tubercle-free milk. In Denmark, the law in this respect is very drastic ; any cow whose reaction to tuberculin is positive must be slaughtered.

The antituberculosis services of various countries are devoting more and more of their attention to the treatment of children : the principal task of health visitors is to see that children and adolescents from infected homes are regularly examined and treated. In France, about 40,000 beds are available for children, a three-fold organization having been set up : aeria for the children of tuberculous parents ; preventoria for those only slightly affected by the disease ; and sanatoria for serious cases.

Chest surgery is everywhere making rapid progress, thanks to modern methods of anaesthesia and to blood transfusion. In the USA, many of the surgical services possess a research centre and a physiotherapy clinic.

A large part of Dr Verghese's report is devoted to an examination of the various social security and health insurance systems in operation. Special insurance schemes for persons suffering from tuberculosis have been introduced in Italy and Switzerland. In France, social security is the responsibility of the State. In the Scandinavian countries, especially in Denmark, practically all the population belong to state-supported private insurance companies. In Great Britain, the National Health Service Act guarantees free treatment to all patients. In addition to the official and private organizations dealing with the treatment of tuberculosis, the existence of voluntary bodies makes possible the follow-up of patients both during and after treatment.

BCG vaccination is used on a larger scale in France and in the Scandinavian countries than elsewhere. The writer of the report stresses that in Denmark the use of BCG, particularly since 1940, has brought about a marked decline in the number of cases of tubercular meningitis observed. In Norway, BCG vaccination is compulsory.

Dr Verghese concludes his report with a comparison between the achievements observed in the West and the antituberculosis campaign, still in its infancy, in his own country.

Notes and News

Practice of Medicine by Foreign Physicians

During the course of the last year, WHO has received numerous inquiries from governments, organizations, and individuals regarding the recognition of foreign medical diplomas by various countries.

In view of the considerable value which the establishment of international reciprocity in the public-health field would offer, the Director-General of WHO has sent a circular letter to the various governments, asking them to forward to him a copy of all legislation in force relating to the conditions under which foreign physicians are permitted to practise or teach medicine or to engage in any profession of a medical nature in a public or private capacity.

Regional Organization for Europe

During its fourth session, the WHO Executive Board had authorized the Director-General to establish a regional organization for Europe once the consent of a majority of the Member States of the region had been obtained.[1] The opinion of the 27 Member States concerned was requested on several occasions by the Director-General ; 21 replies have been received, of which only 15 are in favour of creating this new regional organization of WHO. Although the majority of the replies received from the Governments consulted were favourable, the Executive Board was impressed, during its fifth session, by the appreciable number of European states which either were not in favour of the proposed organization, or had not made their views known. Consequently, the Board decided that it was not yet advisable to take any steps in this connexion and that the matter should be referred to the Third World Health Assembly.

Daily Radio-broadcast of Epidemiological Bulletins

The text of the WHO epidemiological bulletins, broadcast from the Genève-Prangins Station since January 1949,[2] is completely renewed every Friday and repeated on the other days of the week.

However, in order not to delay the transmission of epidemiological news, which may reach WHO at any time, supplementary information is included at the beginning of the daily broadcast. This latest news is followed by the words " End of latest information ", so that health administrations need listen to the radio bulletins only as long as is absolutely necessary.

When the text of the daily bulletin is the same as on the preceding day, the transmission is preceded by the word " repetition ".

Roumania Decides to Withdraw from WHO

In a telegram dated 20 February 1950, the Roumanian Minister of Health made known to the Director-General of WHO his Government's decision to withdraw from the Organization.

In this telegram, the Roumanian Minister of Health criticizes the activity of WHO. In particular, he states that, in the opinion of his Government, " The World Health Organization has not taken concrete measures to carry on successfully the fight for

[1] *Chron. World Hlth Org.* 1949, 3, 243

[2] *Chron. World Hlth Org.* 1949, 3, 35, 92, 243

preventing and combating disease on the international plane and has not contributed in a satisfactory manner to the dissemination of scientific progress in medicine ", and that it " has been transformed into a bureaucratic institution which does not correspond to the tasks assigned it by its Constitution ".

The Member States of WHO have been informed of the decision of the Roumanian Government by a circular letter from the Director-General.

Roumania is the fifth State which has announced its intention to withdraw from the Organization ; the same decision was reached by the USSR, the Byelorussian SSR and the Ukrainian SSR in February 1949 [3] and by Bulgaria in November 1949.[4]

[3] *Chron. World Hlth Org.* 1949, **3**, 56
[4] *Chron. World Hlth Org.* 1950, **4**, 32

Views on WHO

International Co-operation in Malaria Control

In a recent article in the *Archives de Médecine Sociale*, Paris (1949, **5**, 199), entitled " An enemy: malaria; A weapon: international health co-operation ", Hélène Rosebery deals with the problem of the control of malaria on an international scale. She writes :

" Several programmes of malaria control were undertaken in 1949 on a co-operative basis. The national health-authorities of various countries took part in them with the assistance of the World Health Organization (WHO), the United Nations International Children's Emergency Fund (UNICEF), and the Food and Agriculture Organization (FAO).

" But there are still no international quarantine regulations against malaria. Two great agencies of the United Nations, the World Health Organization and the International Civil Aviation Organization, have collaborated in taking the necessary precautions.

" In spite of modern methods of malaria control and the suppression of the disease in a small number of countries, millions of deaths could still be avoided. Furthermore, the hundreds of millions of cases reduce the potential of workers. In addition, any kind of immigration into vast areas whose natural wealth could be developed if they were not subject to the ravages of malaria is often rendered impossible.

" It is, therefore, a question not merely of saving human life, of reducing morbidity, and of raising the standard of living in the countries affected, but also of increasing the world's supply of foodstuffs. At a time when the world's population is increasing at such a tremendous rate, reaching 25,000,000 births a year, it is important to raise the level of production accordingly." *

This article also reviews the programmes which have been carried out and the results obtained in various countries and briefly outlines WHO's plans for malaria control in 1950.

Priorities for International Medicine

A leading article published in *Discovery*, London (1949, **10**, 237), underlines the significance of co-operation of individuals everywhere in campaigns against disease.

" The wise and beneficent plans of the second World Health Assembly will not succeed unless people all over the world do their bit in the worldwide fight against the major menaces to the health of the human species.

" But how are we all to do our bit ? We are not experts and we do not know what the most serious world diseases are,

* Translated from the French

nor how to combat them. Nobody realises this better than WHO and its educational plans are a prominent feature of the programme discussed in Rome. These plans are based on the view that it is better to show people how to get healthy and how to prevent the occurrence of disease than to put up, in each country, expensive safeguards against the diseases prevalent in each locality. These safeguards will be needed, of course, but if people are taught more about the causes of disease and how each disease spreads, and if, at the same time, vigorous efforts are made to eradicate reservoirs of the major diseases of the world, there will be less and less need for heavy capital expenditure on fever hospitals, quarantine stations and similar weapons now employed...

" It would be hard to find aims more beneficent and more urgent than those embodied in the Assembly's programme. Its plans, if they can be brought to success, will have incalculable effects upon the future of a world which is, in spite of political delays, inevitably becoming a unity. They will increase the world's food supplies, substitute happy self-supporting people for the millions who are now badly nourished, ill and unhappily dependent. But the task of the WHO is not an easy one. It will not be done unless ordinary human beings all over the world are willing to help by learning how to keep fit, how to avoid infection with disease and how to help the other fellow to work to the same end."

Support of WHO Programme

Dr J. R. Rees, President of the World Federation for Mental Health, emphasizes the importance of mental health in an article published in the *Bulletin of the World Federation for Mental Health* (1949, **4**, 17).

" The fact that there was agreement from the 70 nations present, on the necessity, and indeed the urgency, of a mental health programme, is significant. The delegate from India said, for example, that, ' in spite of the crying need for elementary public health measures in Asia, the mental health programme would rank in importance there with plans for the control of malaria and epidemic diseases '.

" That it may not be possible to implement considerable parts of the suggested programme through lack of funds, throws still further responsibility on the World Federation for Mental Health. Not only is it our responsibility to discuss, persuade, and shape public opinion with regard to support of the WHO programme, but further it is quite clear that if we can once meet our own essential administrative costs as a Federation, and can then interest large donors in the carrying out of these vitally important survey and educational activities in the various countries of the world, we as a Federation might be able to provide some of the personnel and costs involved in carrying out these projects. This is a point which looms very large in my mind. The established Foundations, such as the Rockefeller, are likely to co-operate with and support the health plan of WHO in many ways. Have we not thus a clear case for building up a foundation specifically concerned with human relations and mental health ?

" One was constantly reminded during the Assembly that, just as in a war, in the face of a common enemy, the aggressions and tensions between groups in any country recede into the background, so here in face of the common challenge of ill-health and inefficiency throughout the world, the personal, cultural and ideological tensions disappeared. The World Health Organization has certainly a greater opportunity for co-operative work than any other agency of U.N. It was fascinating to see how tensions which had begun to manifest themselves were in nearly every case diminished or resolved ; and one could not fail to realise, not merely through the multitude of new contacts made personally, but from the whole tone and spirit of the Assembly, how big a contribution is possible along the lines of human relationships in the international field."

Mental Health Programme

With reference to the adoption of a mental health programme by the World Health Assembly, the August number of the *Presse Médicale*, Paris (1949, **57,** 784), states :

" Problems of mental health play a part in almost all phases of medicine. The World Health Organization is therefore concerned with mental health when it is dealing with aberrations such as alcoholism and drug-addiction ; it is equally concerned with mental health when it draws up programmes for the control of tuberculosis, venereal diseases, and malaria.

" The subject, has not, in fact, been investigated to any great extent. Thus far only one survey on psychoneuroses has been carried out in an industrial community in accordance with practical, statistical methods. This survey revealed that neuropathic disorders caused greater loss of working hours than the common cold. One of the immediate tasks of the World Health Organization, therefore, is to collect complete information concerning the incidence and effects of mental ill-health in a great number of fields. Another important task is to examine the present possibilities of work in mental health. The World Health Organization will also favour the application of improved methods for the treatment and prevention of nervous disorders and will seek to raise the standard of technical education in numerous professions where principles of mental health have an important part to play." *

Positive Achievements of WHO

An editorial in the issue for October 1949 of *Hospital*, London (1949, **45,** 594), comments on the first report of the Director-General of WHO : [1]

" From this first report it would appear that WHO has some positive achievements, and has not allowed its deliberations to run out in the fine sands of argument, counter-argument and constitution-making which one associates so much with international co-operation at the present time. Certainly there is no lack of work to be done by WHO, not only in countering immediate difficulties but in raising general health standards throughout the world, and although a creditable start appears to have been made it will be necessary to await the results of a rather longer period of working before it can be said whether these are simply the first fruits of early enthusiasm or are an indication of something of lasting importance."

Banner with a Strange Device

An editorial in a recent issue of the *New England Journal of Medicine*, Boston, Mass. (1949, **241,** 795), comments on international co-operation in health matters.

" Among the activities associated with the United Nations the World Health Organization stands out as one of the most promising. Its program is reasonable and reminiscent of the good old days before 1914, when the civilized nations united in all sorts of mutually beneficial activities, such as uniform postal rates, copyright laws, weather reports, public-health regulations, the gold standard and hydrographic surveys, and global war had not been heard of since Waterloo except in the nightmares of H. G. Wells. If all nations could really agree on the importance of achieving world health, most other problems would be solved, for nothing is unhealthier than war and its sequelae.

" Medical knowledge has kept pace with the technical advances that have marked a century of progress. This is what the chief of the American delegation to the second World Health Assembly, held in Rome from June 13 to July 2, may have had in mind when he declared in his report : ' Unless we move forward to improve the health of mankind... it is impossible for mankind to move forward.' The statement suggests a pleasing slogan : Gesundheit et excelsior ! What might the nations accomplish if united under a banner with such a device ! "

* Translated from the French

[1] *Chron. World Hlth Org.* 1949, 3, 97

Another Step to Better World Health

Dr K. Evang, Director-General of Public Health, Norway, President of the Second World Health Assembly, describes the new programme of WHO in an article which appeared in the *United Nations Bulletin*, Lake Success, N.Y. (1949, **7**, 106). The author outlines the main achievements of the Health Assembly, held last summer in Rome, and then warns that there is also a " negative side of the balance ".

" Against a truly impressive list of positive results achieved by the Assembly we must place the negative side of the balance —namely, our inability fully to convince our governments of the importance of the aims of WHO and of the vital role which the organization can play in improving health conditions in our individual countries as well as in the world generally. The effects of this failure on our part were evident during the discussion of the funds which were to be placed at the disposal of WHO to enable it to carry out its tasks in the years to come. The lesson we learned at Rome is two-fold. First, WHO must do all in its power to fulfill the aim laid down in its Constitution of strengthening national health administrations so that they will carry more weight with their own governments. Furthermore —and this is even more important—each of us going back to his own country will have to use his imagination and his courage to present to his people the world's health problems in a simple but forceful way. It must be made clear to all nations that while the knowledge and the techniques are available to eliminate many or even most of the ills of man, there are no short cuts to improved health. Indeed, to be established on a world-wide basis health, like peace, calls for sacrifice on the part of every country and every individual in terms of money, work, and prestige."

CORRIGENDUM

1949, Vol. 3, No. 12, page 278

In the list of delegates and observers present at the second session of the WHO Eastern Mediterranean Regional Committee, Dr H. M. Elliott and Dr I. Anis were given as delegates of the Anglo-Egyptian Sudan. Dr Elliott and Dr Anis were in fact advisers both to the Egyptian and United Kingdom delegations, and at the meetings acted as advisers alternately to both these delegations.